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Unto the LEAST

BY DR. E. OSTERGAARD

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by

E. Ostergaard, M.D.

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And the King shall answer and say unto them, Verily I say unto you, Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me."

Matt. 25:40.

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PREFACE

This little book does not pretend to present a complete history of medical work in the Santal Mission, nor even of that at Benagaria Christian Hospital, but rather to give a glimpse or a general idea of what that work consists. Although no mention has been made of other medical missionaries except those at Benagaria, the author fully appreciates the splendid service rendered in this field by former and contemporary doctors, especially Dr. Christine Bodding in Dumka and Mohulpahari and Dr. Dagmar Pedersen in Assam. To the others who more recently have arrived on the mission field, Dr. Otto Forman in Assam, Dr. Kristofer Hagen at Benagaria, and Dr. Else Hoilund, the author extends his best wishes and prays that God may bless them and make them a blessing in the difficult task into which He has led them.

In the history of Benagaria medical work there are those who have not been mentioned in this book by name, although at times by inference, who nevertheless have played a large part in making the hospital what it is and whose association in the service will always be remembered with gratitude, especially so Miss Holten, missionary nurse there for one term and for two difficult periods when there was no medical missionary at the hospital; Dr. Banerjee, a Christian Bengali who for about 20 years offered himself in self-sacrificing service to both rich and poor, and Dr. Chatterjee, who, although not a Christian, has made for himself a place in the work there. To these men and women, to the members of the staff, and to many others who have directly or indirectly given their support, but especially to Miss Holten and Miss Krohn, without whose

splendid cooperation and contributions as nursing superintendents the work could not have been carried on as it was, I want to express this sincere appreciation as well as my personal gratitude.

It is only fair to state that most of the contents of this book are not new. Much has been given in lectures at various times; some of it has previously appeared in "The Santal Missionary" and only slightly revised to be used here. It is hoped that placing it before Mission friends in book form, and thus making it more readily accessible, will increase the desire for greater knowledge and therefore greater love for the medical missionary task.

I also want to express my thanks to the friends who so kindly have given their time to correcting and typing the manuscript in preparation for publishing.

E. Ostergaard.

INDIAN AMBULANCE

Chapter I.

THE PIONEER MEDICAL MISSIONARY

Usually the pioneer missionaries in a new field are not medical men. Rather, they are the ones who have come to bring the Gospel message to the people through the spoken and the written Word. This is quite natural, for the most direct method of telling the old, old story is still by word of mouth, sharing with those who have never heard or who hunger to hear more, that which fills and overflows their own hearts.

Yet the pioneer missionaries have found that in their work of teaching and preaching they have been confronted with so much illness that they have had to become "doctors" and give out medicines to those who come for help. Probably there is no one in our mission, even though without special medical training, who has not had to distribute quinine, cough-medicines, ointments, sulphur, and many other simple remedies. For despite the antagonism against the English Government, it is true that the common people in India still trust the white man, and especially the missionaries. They come to them when sick or in trouble.

The amount of disease in that country is overwhelming. A seemingly endless stream of patients passes through the dispensaries and hospitals. Thousands upon thousands go without medical aid because none is available. They suffer in silence, not knowing that relief is possible, bearing their affliction much as they would a crop failure or the death of a favorite ox, as something to be endured, something outside of their control.

In the face of this great need the call goes to the home countries, "Send doctors and nurses to help us care for these sick people, to erect hospitals and to establish dispensaries, that they may have the medical and surgical help they need."

When the missionary doctor arrives, he sees that conditions are even worse than he could have imagined. There seems to be

BENAGARIA CHRISTIAN HOSPITAL

COOK HOUSE, OPERATING ROOM, AND CONSULTATION ROOM

BENAGARIA CHRISTIAN HOSPITAL

MEN'S WARD

CHAPEL

WOMEN'S WARD

illness everywhere and of all kinds, varying from snake-bite to leprosy, from broken bones to cataracts. He would like to take hold at once, but there are still a number of obstacles he must overcome before he can settle down to full time medical work. The first of these is learning the native language.

DR. B. B. BOGH (right) and DR. BANERJEE

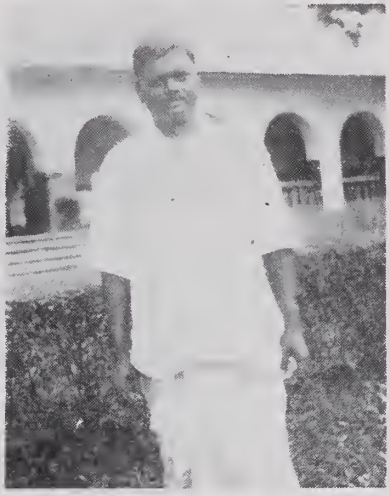
The rule in our mission is that a new missionary shall spend one year in language study without having a definite, responible work assigned. After that he is to pursue his studies along with his other duties. This is a very wise rule, although circumstances do not always permit strict adherence to it.

During the first year there are, of course, various tasks in which one can be helpful, even while carrying on a study of the language. This is especially true of a doctor, who can attend some patients with the help of an interpreter and whose surgical technique is not dependent upon either Bengali or Santali. However, it is essential that he become efficient in the new language because the best way to get into intimate contact with another person and to learn about his troubles and ills is to speak with him in his mother tongue. What joy it is when at last you find that you can understand a few words and that you are understood by the people among whom you work!

A doctor who comes out to a mission field where no medical work has been in progress at once sees the need for a hospital. Patients come from far away, many of them seriously ill, and they must have a place to stay while receiving treatment. In short, a hospital must be built. Dr. B. B. Bogh, who came out from Denmark in 1915, soon realized this. After he had com-

pleted a year of language study, he faced his second problem, that of building a hospital.

It was decided that Dr. Bogh was to begin medical work in Benagaria, which had been the center of mission activities ever since Skrefsrud and Borreson began the work there. The only medical help then available was "doctor" Bhuju, who had earned his title and permission to practice by working for a licensed medical practitioner for some time. Bhuju later became a faithful and trusted worker at the hospital. He was for many years chief pharmacist as well as anesthetist. So. Dr. Bogh had to start at the beginning. He was authorized to build a hospital and was given the old girls' school building to remodel as best he could for that purpose.



HARMA

To build in India and to build at home are, however, two quite different propositions. Here one has an architect to draw up the plans and a contractor to take over the actual work. There the missionary is both architect and contractor and he also has to supervise the actual building. He orders the necessary material from Calcutta or Bombay, he supervises the making of bricks, a process which takes place in the rice fields near the station, where literally tens of thousands of bricks have been made, he teaches the natives to lay the bricks and to mix the plaster and cement in the right way. If he does not know these things himself, which he probably does not, he simply must make it his business to learn. In the midst of all this there are patients to see, operations to perform and sick calls to make. Often Dr. Bogh would be called away from the crowd of waiting patients by his faithful foreman, Harma, to see if

a wall was sufficiently straight or if the cement was properly mixed.

Much had to be learned the hard way, by trial and error, because most of the workers were as primitive as the jungle they came from, and their hands were more familiar with the feel of a bow and arrow than of a trowel or a hammer.

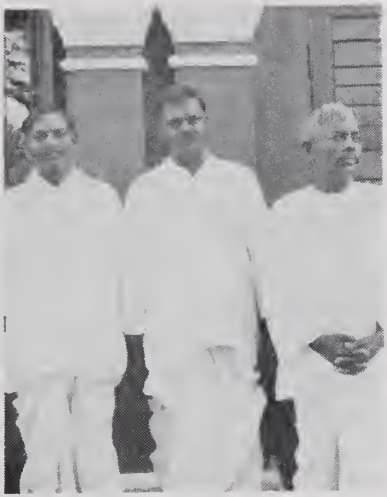
Building the hospital was therefore a slow job, and when I arrived there in 1928, it was still not quite completed. The greater part was finished, however, and the work was solidly and well done, chiefly of brick and cement. When Dr. Bogh and family in 1929 had to leave the mission field because of ill health, he left the nearly completed hospital with an eventual capacity of seventy beds as a fitting outward memorial to the work they had done there in the Master's name and to His glory. Without external evidence but imprinted upon thousands of thankful hearts is the even greater service that he has rendered by his tireless and loving care in helping the sick. Many were the eyes that lighted up in years after when Dr. Bogh's name was mentioned, "Marang daktor saheb" (The great Doctor), as the Santals called him.

The third problem was to obtain nurses. The need of helpers became evident as soon as Dr. Bogh began his work in Benagaria. When it became known that a white doctor had arrived the patients began to come, and a building was acquired for use as a temporary hospital.

But where to get nurses? The concept of nursing as a profession is entirely strange to the non-Christian communities in India. Members of the family will nurse the sick, but the thought of anyone caring for people who are absolute strangers and no relation at all can hardly be entertained. Only during later years and through the untiring efforts of Christian mission hospitals with their nurses' training schools has the idea also penetrated the non-Christian society. Attempts are now being made to create an interest also in those circles for that type of service.

There, however, another obstacle is encountered, which also affects the Christian communities to some extent. That is the

acknowledged place of the Indian girl, which is strictly in the home. It is inconceivable that a non-Christian girl of the better classes could hold any public position and especially one in which she would be in contact with men other than those of her immediate family. Through the teachings of Christianity



THE FIRST THREE COMPOUNDERS
Taken on the 25th anniversary of the Hospital

and by holding up the care of the sick as a laudable service this prejudice has been partially overcome among Christian people, who now more readily send their girls for nurses' training. It is not so in the non-Christian circles, however, where the caste system and class prejudice exist, for these prohibit the women of the better class from entering this type of work, and those of the lower classes, where available, would not have the necessary qualifications.

One more difficulty remains, which is that the Indian girl because of custom and of temperament, usually is married at an early age. In fact, it is quite unthinkable that an Indian woman of marriageable age remain in the single state. There again, the Christian teachings, which place the service to man-

kind in Christ's name before the desire of establishing a home and the example of this seen in the lives of many missionaries has won over many Indian Christian girls to make the same sacrifice. At the time when Dr. Bogh needed nurses there was absolutely none available, so he had to recruit workers and train them himself. He chose to use boys or men, and he was fortunate in obtaining Bhuju and Nimbai, both of whom had some previous medical experience. The others were mostly boys from Kaerabani Boys' School, all of whom had received some education, although often quite limited.

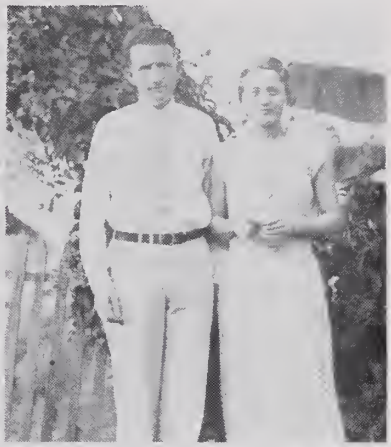
There is a story told of the time that Dr. Bogh was in special need of nurses, or compounders, as they are called. He sent a message to Rev. J. Ofstad in Kaerabani asking if he had someone who would like to take up compounders' training. Rev. Ofstad answered that he had one; his name was Mark. Dr. Bogh wrote back and asked what Mark's qualifications were. Evidently there had been some scholastic difficulties during his stay at Kaerabani, for Rev. Ofstad answered merely, "He has an immortal soul."

Dr. Bogh accepted him, and he became one of our most trusted compounders. For many years he was a clever assistant at operations.

Someone might reasonably inquire if these boys, with only little schooling and not far removed from their jungle environment, would be able to do the work required of them. The fact is that they become excellent nurses. The Santals have a natural instinct for taking care of the sick. They are eager to learn, reliable, and willing. They have shown that they become very competent in carrying out the tasks which they are given to do.

Chapter II

AN INDIAN HOSPITAL



DR. and MRS. ERLING OSTERGAARD
Newly arrived in India

An Indian hospital, although built by a white missionary, is still quite different from one in the homeland. It must necessarily be so, for one has to take into consideration the customs and habits of the people, the shortages in trained help, in equipment, and in diagnostic and therapeutic facilities. Some hospitals are overcoming many of these handicaps and have succeeded in bringing their institutions nearly up to the American standards, but the greater part of the many mission hospitals are still laboring under many difficulties. In spite of this, they are crowded with patients, many of whom have come long distances. They thus extend help to thousands upon thousands who otherwise would receive indifferent treatment or none at all.

Quite naturally, it was with great expectancy that I looked forward to my first visit to an Indian hospital. Arriving on the mission field in November, 1928, by way of Maharo and Dumka, I came to Benagaria on the second day, towards evening. After having supper, (dinner, it is, out there), at Dr. Bogh's, we were sitting in the bungalow talking when someone on the porch coughed. The natives do not knock, but when you hear a cough outside the door, you know someone is waiting to see you.

Dr. Bogh exchanged some words with the visitor in Santali, then turned to me and said, "I have to see a patient at the hospital. Do you want to come along?"

Of course I did. As it had become dark by this time, we took with us a lantern standing near by, a common precaution in India to make sure that there are no poisonous snakes in your path.

We soon covered the short distance to the hospital and entered a general ward containing twelve or fourteen beds. The room was lighted by a kerosene lantern suspended from the ceiling, and I could see that each bed was occupied by an Indian patient. But what attracted my attention especially was that I had to be careful where I walked because on the floor, between the beds and in the aisle, people had spread their blankets and were lying there fast asleep. What a contrast to the strict rules and the privacy of hospitals at home! I wondered who they were and why they were permitted to be there. It was later explained that they were relatives of the patients, who had come to be with them and to help the sick ones.

During the following years, although some changes were made and improvements introduced, we still retained the custom of allowing the relatives of patients to accompany them to the hospital, in fact, we urged them to come. For this there are several reasons.

First, it is the custom. The social system is built with the family as a unit. If one member of the family suffers, they all suffer; if one is ill, the others take care of him. So it follows that when someone has to go to the hospital, several members of the family accompany him, or the whole family may simply move to the hospital to live while the patient is there, bringing cooking utensils, food, dog, children and possibly even a chicken or two to provide food during their stay.

For their convenience two long, low buildings have been erected close to the hospital wards. These are the cook-houses. Each is divided into a number of small rooms of about 4x6 feet. These are without furniture but are provided in one corner with a small, earthen stove on which the food can be cooked.

Each patient and his relatives are assigned such a cook-house where they can keep their belongings and cook their food, and which they can generally call their own. If the patient is ambulatory he is sometimes found in the cook-house or warming himself in the sunshine while chatting with friends.

There is no doubt that this arrangement is well liked by the Indian people and that it helps them feel at home in a place where otherwise so many strange things happen.

Another reason for letting the relatives accompany the patient is the shortage of nursing help. It is generally understood that each patient is to bring an attendant to help him in a general way, and to call the nurse in case that is necessary. Those who come without attendants are given help by the nursing staff. In this connection we must also remember the natural Indian hesitancy both in performing and accepting the more personal services where those involved are not related. The tendency is being overcome but it is one which has had to be reckoned with in previous years.

The patient is also expected to provide his own food and someone to cook it. That is an economic advantage for the hospital where the budget is low and the general charge to the patient is insignificant. Besides, providing suitable cooks for all the patients would present quite a problem because of the many religions and the taboos which do not permit their adherents to partake of one another's food. In our area we have four main religions: Hindu, Mohammedan, Santal and Christian. Of these, the Christians are the only ones who would eat food cooked by any of the others. In addition, the Hindu society is divided into a large number of castes, each of which constitutes a social unit, separate from the others and prohibited from taking food prepared by any one outside their own caste. Thus, in order to please everybody, a number of cooks would be required.

As far as the Hindus are concerned, the problem could be solved by obtaining a Brahmin cook. The Brahmins are members of the highest, or priest caste, and their cooking is acceptable to all the lower castes, but those on the lower scale

could not prepare food for members of castes higher than their own.

The arrangement of having the attendants cook the food is not satisfactory when the patient is on a diet. Even when strict orders are given to the attendants or relatives to prepare

THEY MUST COOK THEIR OWN RICE AND CURRY BEFORE THEY RETURN

only certain things, possibly a liquid or a soft diet, we soon find that the patient is given something quite different, probably a full meal of rice and curry. We hardly knew how to solve that problem, but at last an attempt was made.

Even from the early days of the hospital some diets, including rice cooked for those who came without attendants, had been prepared by the nurses. They used a kerosene stove for this purpose. For the most part, however, relatives or attendants of the patient were responsible for their diets also. During the war, when kerosene rationing began, and our supply was greatly reduced, Miss Krohn, our missionary nurse from Denmark, decided to try another method. A good sized cook-stove for burning charcoal was made in one of the cook-houses and a

Christian woman placed in charge as full time cook. Now we felt that the hospital could supply liquid and soft diets to all who required them. The question was, how would the non-Christians, especially those of higher classes, take to Christian cooking.

We waited expectantly to see how it would go. To our surprise it was a great success; there were hardly any objections. The reasoning is interesting and typically Indian. The non-Christian can take medicine dispensed by Christians because it is given as a remedy for illness. They therefore reason that a diet, also prescribed in case of illness, is to be considered in the same category as medicine and is therefore likewise permissible.

If a patient is too poor to bring food, the hospital of course provides all that is necessary. No one is ever turned away because of race, religion, or economic status.

A trip to the hospital, either for a single consultation or for admission, can be a considerable undertaking because of the primitive means of transportation available and the poor roads. Very rarely is an automobile seen bringing patients to the hospital. If a man has a bicycle, he is considered privileged. Most patients come on foot or by ox-cart.

THE TUMOR WEIGHED 20 POUNDS

Those who are ambulatory and who live near by, naturally come on foot. A large number, even those who are quite ill, walk many miles, sometimes traveling for days in order to reach the place where, they have heard, they will be taken care of. I have a note here, written some years ago, telling of a woman suffering from a tumor weighing twenty pounds, who walked between thirty and forty miles to the hos-

pital for an operation. The note expresses the hope that the return trip will be a bit lighter for her.

Travel by ox-cart is a very slow and cumbersome undertaking. Let us say that a patient lives twenty miles away and wants to see the doctor in the forenoon. Traveling at the rate

A PARKING PLACE FOR OX CARTS

of two or three miles per hour, which is the usual tempo, he would have to start the night before in order to arrive the next morning or early forenoon. There would be several relatives with him bringing pots and fire-wood, for they must have some tea and puffed rice for breakfast. By the time the visit to the doctor is over it will probably be noon, so a meal of rice and curry is prepared before the homeward journey is begun. Thus it will be well into the next night before they can reach their home again. When Dr. Bogh planned the hospital unit, he very wisely included a large "parking" space for ox-carts and planted a number of banyan trees there. These have now grown tall and wide, providing shade and a resting place for both man and beast. On occasions we have counted fifty to sixty ox-carts in this area at one time.

The best way to carry a sick person, and it might well be called the rural ambulance of India, is on a native bed. These are not heavy, being a frame of bamboo or wood, with a leg of the same material at each corner and a net woven from grass cord stretched over the frame. With a piece of rope attached to the corners of each end two loops are formed through which a pole is inserted for carrying purposes. Two or four men can easily carry a patient in such an "ambulance", and in greater comfort and more quickly than in an ox-cart.

Many of the patients that come to Benegaria Hospital are extremely poor. These are charged according to their ability to pay instead of according to the cost of medicine or the service rendered. Santals and those on a similar economic level have very little of which to give, so a straight charge of one anna, (about two and half cents), is made to them for each consultation, which includes medicine. These classes are hospitalized free of charge and very seldom are required to pay for operations. Others, in better economic circumstances, are charged five to ten cents and up to a maximum of about thirty cents for consultation and medicine, depending somewhat on the price of the latter. Some of these are asked to pay a small room charge if hospitalized and placed in a ward. Private or double rooms carry a fixed charge ranging from fifteen cents to thirty-five cents a day.

Operations are on a similar scale. Most of them are free; for others the fee ranges from thirty-five cents to $15.00, which is the most I have ever received for an operation.

If people have nothing, of course no payment is asked, but as a rule it is found the best policy to make a small charge for each visit because the patient then places more value upon the medicine and will be more careful to take it according to directions.

Just how much the various people are able to pay is sometimes difficult to decide. We do not want to do anyone an injustice, so we usually err on the side of undercharging instead of overcharging.

The people of India and of the East in general love to bar-

gain, and no business transaction is ever completed without considerable haggling on both sides. Some have tried to carry this custom into the hospital also, but here it is discouraged as much as possible.

The practice of haggling is not considered dishonest, nor are the many other practices of obtaining a reduction when possible. We sometimes find that well-to-do ladies leave their jewelry and silk "saris" at home when going to the market or to the hospital and dress much like the servant class and so avoid being charged according to their social standing.

Just what is the economic status of a person is sometimes difficult to determine, and even the native workers are at times badly fooled. However, our experience as well as hints from our Indian co-workers have given us pointers which are very helpful. Here are a few.

1. If a man wears a coat he is fairly well off.

2. If a man has gold-rimmed glasses or a fountain pen, he belongs to a well-to-do class.

3. If people are fat, they must be rich, otherwise, how could they get so much food to eat?

4. If a man wears shoes instead of going barefooted or wearing sandals, he is fairly well-to-do.

5. If people arrive in cars they are either rich or missionaries. Others do not have automobiles.

There are no hints given to help recognize the poor people but that problem presents no difficulty.

In a comparison between an Indian hospital, such as is described here, and a hospital in the homeland, our readers may receive the impression that the Indian hospital is so primitive and has so many draw-backs that the patients probably do not receive adequate treatment. That is not the case. These peculiarities of an Indian hospital are inconveniences which have to be contended with and in time done away with completely, but they are not obstacles which preclude an accurate diagnosis in most cases nor the possibility of successful treatment. Modern equipment, technique, and better general facilities are an advantage and a goal to strive for, but it is surprising what can be done without them.

Chapter III

THE MINISTRY OF HEALING

"The church exists to continue the work Christ began. As He identified Himself with the need and suffering of the world, so must His disciples identify themselves with that need and that suffering, that the redeeming love of God may be mediated through them to the lives of others. Mindful of the value that God has set on human personality, and animated by the spirit of compassion that moved the Great Physician, the church will follow Him in methods of service that express His mission. It is her privilege, as it is her duty, to give effect in Christ's name to the redemptive purpose of God, whose end is the restoration of the divine image in man. The Ministry of Health and Healing belongs to the essence of the Gospel and is, therefore, an integral part of the mission to which Christ has called, and is calling, His Church."—From the Tambaram Meeting, 1938.

When the first missionaries were confronted with the many sick people who came to them for help, could they not have turned them away with the excuse that they knew very little about medicine and were not competent to treat them? We would certainly not have judged them harshly if they had. But they did not turn them away, they helped them to the best of their ability. Why? Because He who had compassion upon the suffering multitudes and healed their sick had also touched the hearts of these His servants with a passion to help and to alleviate suffering.

That was the Ministry of Healing. It is multiplied a thousand times over in the hospitals, dispensaries, and leper colonies of India where Christian men and women are fired with the same compassion that they see in their Lord and Master, Jesus Christ, and reveal it in their ministrations to the sick. It is

more than giving medicine or making a bed; it is doing this in the spirit of Christ.

This means that the task of the workers is an expression of God's love. It is not an easy accomplishment, to be sure, and it is realized even in part only by consecration and constant prayer. But they do so need to feel that someone cares for them, these brown-skinned men and women who so little know the meaning of God's love; for their own gods and evil spirits do not love them. Probably their stay here at the hospital is the first time that anyone outside the immediate family has shown any concern for them. They may have been lying out in the small mud hut in their village for days and even weeks, burning with fever and growing weaker day by day. The members of the family do what they can, but they are too busy to give them much care. Nor is there much that they can do, except to give the herbs prescribed by the medicine man, drugs which nearly burn up their insides but do no good. At last the family agrees to take the patient to the Christian Hospital where, people say, many are cured.

When the patient arrives, he is given a clean bed with a white sheet as cover. "How foolish," he thinks, "to waste a clean sheet on such as I." But every one is kind, and that night he receives an injection and so gets the first sleep he has had for many days. In the morning another nurse comes to straighten his bed and make him comfortable. Later he is given medicine that cools the fever in his blood, and he rests better. The missionary nurse and doctor come and ask him how he feels. He is questioned about his illness and examined thoroughly. Gradually he begins to feel better; his forehead is not so hot, and his appetite begins to return.

Now that he is improving and has time to think, he begins to wonder about all this that has happened to him. "Why are the nurses, Santals like myself, so concerned about me that they work early and late to help me get well? And the missionary nurse and doctor, I wonder why they came across the great oceans to help us? Some of the patients say that they came here to make money. They do wear good clothes, and some say that

they eat meat every day . . . Still I can't believe it is true, as I have paid nothing and neither have the other patients that I have talked to in the nearby beds. I wonder what it can be."

One afternoon a man with a happy voice and kind eyes enters the ward. He has come in every day, but our patient has been too lethargic to pay much attention to him. Today he sings a song and tells about a God, "Who so loved the world that He gave His only begotten Son that whosoever believeth on Him should not perish but have everlasting life."

"That must be the white man's God," the patient thinks, "and not for the likes of me."

The evangelist continues to explain that He, the one and true God, does love every one in the world, whether he is white or black or brown. To reveal that Love, for their sake, He was willing to send His only Son to suffer and die on the cross. "So great," he says, "is the love of God for each one of you right here. He wants you to get well, both in body and soul, so you can have peace in your heart and freedom from fear."

A great wonder fills the heart of our patient. A God Who loves him, a poor Santal, whose only religion has been one of fear, fear that some action of his might offend the evil spirits and that they would work their vengeance upon him in some cruel way. "So that is why every one is so kind here," he concludes, "and that is why the doctor saheb and the white nurse have come way over here, because their God is the God of love, and they want us to know that it is for us, too."

He lies quietly. There is much to think about, much that he does not yet understand. But a new peace fills his heart, a new spirit of reverence and worship that he had not known before. For the God of Love is also his God; the evangelist had said so.

—So the Ministry of Healing, itself an expression of the Gospel of Jesus Christ, leads normally to the proclamation of the Gospel through the written and the spoken Word.

Chapter IV

HOSPITAL EVANGELISM

"We must put evangelism at the heart of the hospital and the ministry of healing at the heart of the whole missionary program." — Bishop Pickett, of India.

ATUL A. BISWAS AND WIFE
Evangelists at the Hospital

Between the men's and the women's wards of the new wing of the hospital lies the beautiful chapel, a fitting symbol of the place evangelism has in the mission hospital. Here every morning the day's work is begun in song and prayer to Him, in whose name the work is to be done. This devotional period is mostly for the members of the staff, but the patients are also invited to attend, and usually all available space is occupied. The Bengali and Santali languages are used on alternate days, and the custom has been that missionaries, nurses, and evangelists take their turn in leading the devotions. On Sunday the small Bengali congregation in Benagaria uses the chapel for church services, again giving the patients an opportunity to hear the Gospel message.

When the out-patients gather on the broad veranda of the dispensary building to await their turn in the doctor's office, there is ample opportunity to speak to them. This is usually done by the hospital evangelist or at times by one of the other hospital workers. In this work, amid disturbances, the coming

and going of patients and a generally restless assembly, illustrated charts with pictures of various scenes from the Bible help materially to emphasize the speaker's message. Frequently questions are asked, and a conversation may be started which develops into a serious discussion on religious beliefs.

It cannot normally be expected that people whose religion is older than Christianity, as is Hinduism, will at once discard their old beliefs and embrace new teachings. Conviction of the validity of these teachings, and more than that, conviction by the Holy Spirit that there is no way except through Christ for eternal life and salvation, is necessary for a conversion. That does not and should not come quickly; only through a period of growth can it ripen into maturity.

But here the seed is sown. Probably among the thousands who through the years have come here for medicine and help the Word has mostly fallen on barren ground or amid thorns, but surely some has found good soil where the seed has taken root and borne fruit.

Among the patients that are admitted to the hospital, however, a more effective evangelistic work can be accomplished. As the patients are there longer, there is a greater opportunity to reach them with the Gospel as expressed both in word and in deed. Here the friendly, helpful attitude of the hospital workers can be felt. There is no need for bribes, which would be required for the slightest service in most secular hospitals in India. The medicines given are "good" medicines, meaning that they are effective and not diluted or of poor quality as is often the case in government dispensaries.

In the atmosphere of confidence and peace thus created, the evangelist has unique opportunity to reach the patients with the Gospel message. This he does through songs and through talks, which often lead to conversations with individuals or small groups who have shown special interest.

As they lie recovering from their ills, patients also have time to read. Some receive tracts or buy Gospels or a copy of the New Testament and occasionally the whole Bible. I remember some years ago a Hindu youth was at the hospital for some

time. Having some knowledge of English as a student in high school, he asked for a New Testament in English. This he read practically without stopping. When he had finished, we asked him what his impression was. He answered, "I have read our own Holy Scriptures and find much good in them but also much that is not good. In the New Testament there is only good."

Another Hindu, a Brahmin from a nearby village where there are many Brahmins, (members of the priest caste), and numerous temples, came to the hospital with an infection in his leg. He asked to borrow a Bible, and as his leg very slowly healed, he read and read. It seemed that no matter what time I came into the ward, he would be reading the Bible, entirely captivated by what he found there. One day I asked him if he thought that what he read was true. He answered slowly and with conviction, "Yes, saheb, it is undoubtedly true."

A few days later I talked with him again and asked him, "As you realize that this is the true Gospel, when are you going to accept it as yours and Christ as your Savior?"

At this he was silent and an expression of unutterable sadness came over his face. Was he not a Brahmin from a village of Brahmins, a teacher of the people? What would his fellow caste people say? What would his family do? He would be cast out of the Brahmin society and become an outcaste, a Christian, one whom his fellow-villagers would look upon with scorn. He would not bathe in the village pond, he could not share a cup of tea with his neighbors.

Can Christ demand that much? And yet He does.—"Jesus said to him, If thou wouldst be perfect, go, sell that which thou hast and give it to the poor and thou shalt have treasure in heaven: and come and follow me. But when the young man heard the saying, he went away sorrowful; for he was one that had great possessions." Matt. 19:21-22.

This Brahmin priest also went home, sorrowful, for he, too, was rich, although not in material things.

I wonder if we here at home, who through infant baptism

were admitted to the Christian Church, fully realize what it costs for a non-Christian in a heathen land to become a Christian. It entails a complete break with all they have known since childhood, with beliefs, friends, social activities, yes, often with father and mother, wife and children. Surely it behooves us, whose trials have not been so great, to pray more diligently for those who must sacrifice so much, that they may have courage and strength to become followers of the Master.

Some years ago a responsible evangelistic work among the patients was begun by members of the staff. It really originated among the women nurses. There were five or six of them, who under the guidance of the missionary nurses, held meetings for the women patients and their relatives in the afternoon several times a week. These were so well attended and so encouraging that a plan was put into action for the male members of the staff to carry on a similar work. In the evening after the hospital work was done, they would go into the wards and bring the Gospel message in some way to those who would gather about. Not all the compounders, some of whom were just out of school, felt that they had a message to bring. If they insisted that they could not, they were not compelled to do so. Others were encouraged to go with the older men until they became accustomed to talk with others about religious matters. Not all felt that they could preach or give a talk, so instead they would sit down at the bedside and converse with the patient, telling what it meant to them to be Christians and explaining the meaning of Christianity.

The fact that these men, who during the day were busy giving medicines, operating, or looking through the miscroscope, would come in the evening and talk with the patients, did give, I believe, an increased emphasis to their message. To me, it brought a deep, personal satisfaction to gather a group of patients and their relatives and to tell them about Him Who gave up His heavenly home to be born as lowly and as poor as they, in order to show them the way to eternal life; or to talk with the individual patient and to learn about his fears and troubles. Many an interesting story has been revealed where

sickness and disappointments, doubts and fears, resulted in the individual finding his way to Benagaria Christian Hospital.

One such patient was a tall, elderly Santal, a village chief. He had been fairly well-to-do. However, he had become ill, and gradually all his money and property had been spent in offerings to the bongas, (the evil spirits), and to pay the medicine man. Nothing had availed; he had only become worse. Now he had come to the Christian hosptial, poor, sick in body, disillusioned as to the power of the bongas, and with a mind open to whatever he might meet here.

"Why do you continue to worship the bongas?" I ask. "Do they ever help you?"

"Help? Ho, ho," he laughs at the idea. "No, they do not help; they only try to harm one."

"If they do you no good, then why not leave them? You seem to have suffered sufficiently at their hands."

"Well," he answers, "they might also cause illness or even death to my wife and children."

The Santals believe that the evil spirits cause any and all calamities to befall them, such as illness, crop failure, or even the death of one of their dear ones. Then they must bring an offering to the evil spirits in order to appease them and to induce them not to inflict any more damage.

That was my opportunity to tell him of the one true God, Who is more powerful than all the bongas, and that to believe in Him is to have release from the fear of evil spirits and to receive eternal security in His strength. The old chieftain listened intently until his eyes kindled with a new hope, the hope that alone could give meaning to his shattered life.

Another way in which the Gospel is preached at the hospital is through the Christian patients who come there. It is not so much that they actually preach to the others—only an occasional Christian visitor has done that—but they testify by the life they lead and by their conduct while at the hospital. About twenty per cent of the patients are Christians, so their influence may well be greater than we can judge, even though they are quite unaware that they are witnessing for their Master.

Once a Christian father and mother brought to the hospital their little girl of nine or ten years, who was very ill with kidney trouble. Her whole body was swollen from the disease, and after we had examined her, it was evident that the little patient could not recover. We kept her there, however, to do what we could for her. I happened to be at her bedside when the end came, and so were the father and mother. When they saw that the spirit had left the body, the mother began to sob violently. After a few seconds the father placed his hand gently on her shoulder and said, "Don't cry. You know that our little girl is a Christian and she has only gone before us to her heavenly home. You and I are getting old, and it won't be many days before we, too, shall go. Then we shall be together again, in the place where there is no more death and no more parting."

With this the mother's sobs were stilled. She still cried, yes, for the sorrow and the emptiness remained, but she became calm. A quiet peace came over her and her husband at the thought that this was not the end but that a new life was awaiting them, because they believed in the risen Christ.

This may not sound like such an unusual thing here in a Christian country, but out there where the Christian hope of the resurrection is not known, to the Hindus, the Mohammedans, and the non-Christian Santals, it was a powerful witness. When we know how they take the death of one of their dear ones, we can understand; for when a Hindu or a Mohammedan dies, the women immediately throw themselves on the ground, tear their clothes and loose their hair and set up a wail that can be heard far away. It is the death wail, loud, shrill, penetrating. The doctor's bungalow is about a block from the hospital, but when we hear that peculiar wail coming from there, then we know that a non-Christian has died; died without Christ and without hope.

A Christian funeral can also be a witness. When Mrs. Skrefsrud died at Benagaria, only two short years after she had come to the country, Skrefsrud himself lay ill with the fever. The day of the funeral he got out of bed, and was as-

THE DOCTOR'S BUNGALOW

sisted to his wife's grave. Standing there, with the tears running down his cheeks, he spoke to the gathered multitude, which was composed mostly of heathens. His words were not of the sorrow of parting or of grief at his loss. No, it was a witness of the power of the resurrection, and of the assurance that he and his wife, together with all who believe in the risen Saviour, would meet again in their heavenly home.

At the hospital when a Christian dies, we have the funeral service on the hospital veranda. All the workers that can get away gather with us; hymns are sung and the Gospel of the resurrection is read. Sadness and sorrow, yes, but through it we feel the quiet joy of the hope of the resurrection. The heathen see and marvel. And who knows, maybe one of them will be drawn by that witness towards the Saviour.

So through the written and the spoken Word, and even through illness and death, the Gospel is proclaimed. May God bless it, so that it may fall in good soil and take root and bear fruit.

Chapter V

A DAY AT THE HOSPITAL

The day at the hospital starts at 7 o'clock in summer and 7:30 in winter. We begin a little earlier in summer as the patients travel during the night or early morning in order to avoid the hot sun, and so come to the hospital earlier. In winter we begin a little later because the Santals and others like them must necessarily sit in the sun a while to get warmed up before they can generate enough energy to do anything. Probably the rest of us have something of the same failing; we hate to leave the warm bed and get out in the cold, sunless air when the thermometer registers as low as 50 degrees,—well, at least it feels cold in the unheated houses.

So we linger over the breakfast and the morning mail until the hospital bell informs us that it is 7:30. If you care to accompany us to get a first-hand glimpse of the working of an Indian hospital, you are very welcome.

First we all gather at the hospital chapel for morning prayers, which today are conducted by one of the compounders. Then the "rounds" begin, at which medicines are prescribed for the day and dressings done. We start in the men's ward in the new wing. There are 12 beds, all of which are occupied. In the first two are two Mohammedans, both suffering from chronic malaria and both from the same part of the country, thirty to forty miles away. They were placed together with the thought that the two followers of the Prophet would get along well with each other but it was found not to work out that way. They quarreled continually. One day they started arguing while we were making rounds, so someone suggested that we would have to put a Hindu patient between them to keep peace.

In the next bed lies a Santal, a non-Christian, who was gored

by an ox. His story is interesting because his is not an isolated case. Nearly every year at the time of the Santal heathen festivals a case of this kind comes in. During the celebrations it is the custom that everyone imbibes freely of the intoxicating liquor which is made from rice, and so they are found in a constant state of intoxication as long as their festivities last. It is a disgusting sight one sees when one goes into a heathen village at such a time. Everyone from the old, bent grandmother, who limps along with the help of a sick, to the small child who has just learned to walk alone, everyone is, literally speaking, drunk. The time is spent in dancing, drinking, singing and in various disgusting practices which serve as sport and amusement. It was in one of these, a type of bull fighting, that our patient No. 2 received his injuries. Exactly what takes place at such celebrations I can not say as I have not witnessed it, but I am told that a bullock is tied to a tree or a post and then prodded and tortured in some way until it becomes furiously angry. What the purpose is I do not know, but there evidently is some kind of fight between the men and the bullock, or an attempt to throw the animal. At least the game is not without danger, of which our patient is a sad witness. He is not expected to live as a horn has penetrated the one lung and the heart has also received injuries.

We move on, however, to see the other patients. Nos. 4, 5 and 6 have been operated for cataract. There are, as you know, many cataracts in India. It is a disease in the lens of the eye causing blindness on one or both eyes. The only known cure is the removal of the lens, which is accomplished by a very delicate operation. After the operation the patient must be in bed with the eye or eyes bandaged for nine days. It is quite a trial to remain quiet and in darkness that long, but their reward comes when the bandage is removed and they find that their blind eyes can see. Their joy is great. One of these patients was blind for four years. His operation was successful and he has regained the sight of both eyes.

Many of these patients are very poor and have come long distances, begging as they go, in order to get to the hospital. The

lot of the blind in India is a hard one. He cannot work, so why should he eat? He is a burden to the family; he is only in the way, yet as long as he is there, he must have food. Therefore, he is often sent out to beg for his living. If his blindness is due to cataract, his prognosis is of course good, but a great deal of blindness out here is incurable. Most of it is preventable, but competent medical advice has not been sought in time. Very probably it has not been available.

BEGGARS, the man blind from cataract

The rest of the patients in this ward are not of any especial medical interest. But as human beings they are interesting as well as a mixed lot. In the corner bed is a low caste Hindu whose faithful wife looks after him with tender care. Next to him lies an old, non-Christian Santal, the stolid, slow-moving type who is happiest when he is at home in his village or working in the fields. Next is a Mohammedan who has trachoma. Long-suffering and uncomplaining, these bewhiskered worshippers of Allah are thankful if they can be helped, but certain, if they cannot, that it is the will of God and that therefore they must bear the affliction patiently. The next is a Christian Santal, who was a driver (chauffeur) in Dumka until his sight failed him. He is improving slowly.

In the private rooms, of which there are three, two double rooms and a single, we have two patients that have recently been operated upon and another who can afford to pay for the luxuries of a private room.

We will now go over to the women's side, but as we pass the nursery or "orphanage," let us just take a glimpse at the orphans.

We have only three now,—there you see two of them taking a sun-bath. People sometimes ask if they are not twins, to which we laughingly reply that they can hardly be as one is a Santal and the other a Mohammedan. We took them because their mothers were dead, and we could see that if they remained with their fathers, they would quite certainly die from lack of care. They will be returned to their families, however, when they are big enough to eat rice. The other orphan is a Christian Santal, that is, he is not a Santal and was not a Christian when he came to us. That sounds a bit paradoxical. Well, his father

TWO SANTAL NURSES AND MISS HOLTEN HOLDING AN ORPHAN

is a Pahari, a people who have much similarity to the Santals, and as his mother is dead and his father has disowned him, we baptized him and gave him a Santali name. Now, one of the Santal pastors has asked to adopt him, so we are sure that he will be well taken care of.

On the women's side here in the new wing we have three private rooms, just as on the men's side. One of these is kept for maternity cases. When the hospital was first started, we had very few of this type of patients. Most of those that came

were the ones that were given up by the native midwives, or "dais", and as a last resort were brought here. Through the years the people, and this is especially true of the Christians, have learned to appreciate the cleanliness and good care available at the hospital and so are bringing more and more normal cases for delivery. These are taken care of by the women nurses who have been given special training in midwifery under Miss Krohn's supervision. These nurses also go out, two by two, to take care of deliveries in the homes. So gradually the people of the community are being educated to forsake the dirty, native "dais" and accept the clean technique of the hospital workers. But this influence is still local, and an enormous amount of education as well as actual demonstration is necessary to spread the desire for such help. We also need many additional trained midwives to make this aid available.

MISS KROHN

How great this need is we have occasionally seen when called out into a village to see a woman in labor whom the native "dais" have been unable to deliver. And, by the way, these native midwives are the dirtiest and most ignorant of the lowest classes of Indians. Cleanliness has no place in their technique, nor is it expected. The woman in child-birth is considered contaminated and treated as such. She is placed in the smallest, dirtiest, and stuffiest room in the house; her clothes are taken from her, and she is covered with old rags. If there is a window or some cracks in the wall that might admit fresh air, these are stuffed with rags. The heat outside is extreme, and in this little room it is nearly unbearable. Yet often, and always after the baby is born, a fire of wood or cow-dung is placed in a broken

earthen pot near the bedside, making the already stuffy room a veritable furnace of heat and smoke. It burns the eyes and causes the perspiration to pour forth. One wonders how the poor woman survives both this and the ordeal she has just gone through. May the future bring relief to the suffering motherhood of India!

But we must hurry on as it is getting late.

In the women's ward there are twelve beds, as on the men's side, and we find much the same type of cases. Among both the women and children there is a great deal of eye disease, especially trachoma and corneal ulcers. The women also, as you can see, present a mixed group—Santals, Hindus, Mohammedans, and Christians, lying side by side. Of course, the strict "purdah" women do not often come to the hospital, and even the more liberal high caste ladies wish to stay in private rooms, although some of the less exacting are satisfied if they have a curtain around their bed.

In the old wing of the hospital there is room for about thirty or more patients. In one part of this are kept the unclean cases such as ulcers, abscesses, and open sores. Another part is used as isolation ward for want of a separate building for contagious cases; such are comprised mostly of dysentery, typhoid, more rarely diptheria, mumps and measles. Occasionally we have had to take in a cholera case, but we try to keep such patients outside of the hospital proper.

Now I am sure that you are tired of all this medical talk, and as it is time for mid-forenoon break we shall go home for some refreshments and a few minutes of rest before returning to see the out-patients, who are already gathering on the veranda.

Today will be a busy one, for it is market day, and so there will be a large number of patients. The market lies only a short distance from the hospital, and of the crowds that attended it, a larger number also use the occasion to come to the hospital. As you see, quite a number have already gathered on the veranda or are sitting on the ground. Atul Babu and Ramu have just finished preaching to them, and they are now being regis-

tered in order to get their tickets which will admit them to the consultation room.

On market days, which occur twice a week, we try not to have any major operations scheduled because they take so much time. So today there are only a few cataracts, and these Dr. Banerjee has already started to do, so we shall proceed to see the out-patients.

The "chaprassi" (door-keeper) has orders to admit only three patients at a time, but although he is a big, strong chap, he has great difficulty in holding them back, because they crowd and push, and even dodge under his arms in order to come in as soon as possible. No wonder, either, for they know that the last ones may have to wait 5-6 hours before they can be taken care of.

As you can see, these people constitute a heterogeneous group: Hindus, Mussalmans, Santals and Christians, both men and women, and with styles of dress that vary from nothing but a loin cloth to the well-dressed man in shirt, coat and shoes, and the semi-purdah lady with her head covered and arms and legs heavy with bracelets and anklets. For the purdah women there is a separate room with an entrance through a side door, through which they can enter directly from the ox-cart and so avoid being seen by any strange man.

The diseases these patients bring, or as you might say, that bring them, are as varied as their hosts. Malaria, intestinal worms, eye diseases and skin diseases are the most common, but anything is like to turn up. Once a man came here for treatment of his toes which were badly ulcerated as a result of frost-bite, a condition you would hardly expect in this part of India. This man, however, was a Pathan, whose home is in the northern part of India but whose trade as a cloth-merchant brought him to this part of the country.

As there will not be time to discuss each one of these patients as they come, I shall take only the cases that are most typical or interesting and tell about them.

Here comes a woman with a baby one and half years old. I look at the chart; the diagnosis is congenital syphilis. The

woman begins the conversation in a somewhat impatient tone of voice: "I have gotten medicine from you twice now and the sores are not healed yet."

I explain that in that type of disease she will have to get medicine for a whole year or even two in order to cure the disease. "Moreover," I continue, "if you and your husband do not take injections all your children will either be like that or maybe dead."

"But," the husband says, "I have taken injections."

"How many?" he is asked.

"Three," he answers.

So more explanations are given to the effect that three injections do not cure syphilis, but that many months of treatment are necessary.

Satisfactory treatment of that much dreaded disease is nearly impossible in this country. The price of the medicine alone is a practically insurmountable obstacle, for people simply do not have the money to pay for it, and there are no public institutions with exception of a few mission hospitals that give the medicine gratis. Moreover, these patients want to be cured in a hurry, and if they find that the treatment will take a long time they frequently do not return but go to some quack who promises a quick cure. The result is that they never recover completely, and their children inherit the loathsome disease.

Next comes a Santal. I ask what the trouble is and he answers, "Fever." "What time does it begin?" He points to the direction the sun will be at about three o'clock. I ask if he has chills. He admits that he has when the fever begins. So I hurriedly examine him and find that he has an enlarged spleen and tenderness over the liver. It is a typical case of malaria, and he gets the usual cinchona (quinine) and a dose of salts.

Such cases are very numerous, but it is not always that they so quickly reveal the nature of the disease. Sometimes their only complaint is headache, or pain in the body, or that they are not able to eat rice. Then it is only after considerable questioning that it can be learned that they have had fever for about a week.

The next man is a Hindu, a Brahmin by caste, as you can see by the holy cord he wears around his neck. He is slight of build, lighter in color than most of the others, and his sensitive features have a somewhat nervous appearance. I ask him what his trouble is, and he takes a long breath and begins: "I suffer from dyspepsia, saheb, and liver—", and he launches forth on a long story about his troubles, occasionally refreshing his memory from a piece of paper where he has written down his various symptoms so that he will not miss any. I take the opportunity to examine one of the other patients and let him continue his story. When he has finished I ask him what his occupation is. He answers, "Oh, I don't do anything, saheb. I am a poor Brahmin and I live at home." "But how do you eat? (i.e. how do you obtain money to buy food)," I ask. "Oh," he says, "I live with the family."

From this it is evident that his is another of the social parasites of which India has a great number. The family consists of the male relatives and their wives and children and the unmarried sisters. Those people live together as one family in one or several adjoining houses. Sometimes they have sufficient land to support them, some times one or two of the older members earn enough for all, and again, if they are Brahmins, their officies as priests bring some remuneration. But the family system gives ample opportunity for those who are so inclined to loaf away their time and worry about their "dyspepsia", for each member of the family can claim his maintenance in the joint household. The man is asked a few more questions and he gets a prescription and leaves.

As he goes, three or four of the other patients push their admission tickets towards me in order to attract my attention. I notice that there are about ten patients in the room whereas the chaprassi has orders to admit only three at a time, so I ask him where they all come from. "Saheb," he says, "they come in through the other door (the exit). I tell them to go away, but they won't listen." So we pick out the offenders and send them out to await their turn with the rest.

Next comes a young Bengali who has a pinched face and an

emaciated appearance. Then someone tries to get in through the exit, but I see it is the Brahmin and ask him what he wants. He says, "Saheb, ki khabo?" (Saheb, what shall I eat?) And I realize that I have omitted that most important factor in Indian therapy, namely, diet. For most Indians, not the Santals, however, believe that as soon as there is the least bit wrong with them, they must go on a diet and especially avoid rice. Very often patients whose only trouble is a cut finger or something similar will ask seriously if the doctor thinks they should avoid eating rice and curry. Frequently patients come to the hospital in a weak and emaciated condition because they have unnecessarily deprived themselves of food. So I tell the Brahmin what he should eat and turn again to the young Bengali.

We inquire what his trouble is, but before he can answer, his old mother, who has accompanied him, throws herself at my feet, takes the dust from my shoes and touches it to her forehead, while she wails in a tearful voice, "Master, I am a poor woman and have no one at all, no father and no mother. You are my father and my mother. I have come a long ways. Please look at (examine) my boy carefully."

This is of course done to arouse sympathy, so I ask her to get up and tell me something about the boy's illness instead of wasting time. At that they both start to relate their story, but with the two of them talking it is not possible to make out what either one says, so the mother is told to be still and let the boy talk. It then becomes clear that he has had a long siege of intermittent fever which no medicine seems to help. Now the old woman again tries to give helpful information. (She has been quiet for about ten seconds). She is again told to be quiet, and I go on with the examination but am again interrupted; the Brahmin sticks his head inside the door to inquire if he can eat rice once or twice a day. He is told that he can eat rice only once a day, at which he is satisfied and goes away.

Proceeding to examine the boy, I find that he has a very large, soft spleen and even then some fever, probably due to kala-azar. By this time the old woman has enlisted the interest of the other patients and proceeds to give them an account of

her troubles. But as the boy now has to go to have his blood examined, she goes along and there is comparative quiet again.

Seeing the out-patients sometimes does tax one's patience, but one learns that it does not pay to become irritated or impatient as nothing is gained and much can be lost. You wonder if it would not be simpler to see one patient at the time. Yes, it would be simpler and much more satisfactory, but it would take more time, and when two doctors have to see 250 to 300 patients a day besides the rounds and minor operations, there is no time to waste. Many of the cases, such as scabies, ringworm, malaria, etc. are quite simple and quickly diagnosed and prescribed for. More difficult cases and those of a private nature are taken into the private room you see to your left and examined there.

Here is a child with a large abscess of the thigh which must be operated upon. While the instruments are being prepared, let us see how the rest of the work is going on.

Adjacent to mine is Dr. Banerjee's consultation room. He has finished the cataracts now and is also seeing the out-patients. To the right is the drug room where three or four compounders are giving injections, doing dressings, and preparing for minor operations. Here is a patient waiting to have a couple of teeth extracted, so I will do that at once. That is quickly done unless we stop to anesthetize the nerve, but as this takes too much time, it is done only when the tooth is a difficult one or the patient is very particular.

Further on is the laboratory where two men are busy with the various examinations. Let us go in and see if he has examined the Bengali boy who was suspected of having kala-azar. Yes, the one test is positive. The other will be reported later. A third test will show whether or not the blood contains malaria parasites. But it is very likely kala-azar, and the boy will recover with the proper treatment.

The further room is the operating room where major surgery and minor clean cases are done. Now there is nothing going on except that the compounders are tidying up after the cataract operations.

They have now prepared for the operation, so let us return to the dressing room. The anesthetist gives a few whiffs of chloroform. The child is asleep, and the abscess is quickly opened.

It is now nearly noon, but there will be time to see a few more patients.

Please note the first one. I know the type, and instinctively draw my legs up under my chair. Yes, he throws himself on the floor and tries to embrace my knees. I avoid him, but he remains lying on the floor, whimpering and crying, and makes the usual plea for sympathy, "I am a poor man; I have nothing at all, no father and no mother. I have begged all the way to get here. Now I fall at my master's feet and beg you to have mercy."

I tell him to get up and let us know what ails him so that we can give him some medicine. This he does at last, and he gets the necessary prescription.

Probably all Westerners have an inherent dislike for that type of crying and whimpering individual. Instead of facing his troubles and bearing them like a man, he cringes and grovels in the dust like a dog that expects a whipping. But it is not his fault. He is one of the outcastes, and his people have been so for generations. They are considered as the dust under the feet of those of the higher castes, as a dog or worse than a dog, and they are treated as such. They must cringe and grovel in order to live. It is a pitiful condition, and one wonders how long India must suffer under the yoke of the caste system.

Among the rest of the patients there is just one that I want to call your attention to. It is the man with the flushed face and labored breathing. Just notice his cough. Yes, even without an examination there is no doubt about his diagnosis: advanced tuberculosis. And he is only one of many, oh, so many. How pitiful they are, because their condition is so hopeless. Day after day we see them in the dispensary, and we are powerless to help them. We send them home with some medicine and tell them to stay in bed and eat nourishing food, but for most of them that is impossible. They are working people who live

from hand to mouth and have no money to buy good food. We could take them into the hospital for a week or two, as is sometimes done with the earlier cases, in order to teach them to take care of themselves, but they cannot be kept there long for they would soon fill the hospital to the exclusion of other types of patients who can more readily be helped.

Truly, I believe that their case is more hopeless than that of the leper. For the latter colonies and hospitals are available and numerous out-dispensaries have been erected for their treatment, but for the tuberculous patient very little has yet been done. In 1941 there were sixty-two Mission Leper Homes and Hospitals, but only ten tuberculous sanatoria. There are also a few government sanatoria in the country, but total number of beds available for these sufferers is entirely inadequate to care for even a small fraction of the thousands who are afflicted with this dreaded disease.

In the province of Bihar there is a government sanatorium to which we have at times considered sending some of our patients. Upon inquiry, however, we have found that the Indian wards were always full and that there was a long waiting list and even if there were room, the monthly charge would be prohobitive as it amounts to twice the salary of one of the hospital nurses.

This patient is an advanced case; and much as we would like to help him, there is nothing we can do except to give him some medicine to ease his cough and send him home.

But now it is noon, and we must go home for lunch. In an hour or so I shall return to see the rest of the patients, but as you have probably seen as much as you care to, it is better that you follow the excellent custom of taking a nap during the hottest part of the day instead of going back to finish the day at the hospital.

Chapter VI

THREE OF THE "LEAST ONES"

By Mrs. E. Ostergaard

Bhogot

Bhogot's round Santal face breaks into a bright smile every time you look at him now. He is learning to walk with crutches these days, and that is quite an adventure after a boy has been on his back for nearly five months. For Bhogot has only one leg; the other is gone from just below the hip. But his one leg is growing strong again, and his brown body is becoming round and healthy.

It is not the same Bhogot who was carried to our mission hospital one hot day eight weeks ago. Then his leg was an infected, distorted mass, with broken bones protruding thru the flesh, and the whole thing could hardly be recognized as a human leg. His face was pinched and drawn from three months of torturing pain, his body was thin, his abdomen and the supposedly good leg were very much swollen. His blood, too, was very low, and he was exceedingly weak. Dared the doctor am-

BHOGOT IS HAPPY NOW

putate in such a condition? But to leave the leg with all its infection would mean almost certain death! With a prayer on his lips the doctor stepped forward to do what he knew was necessary.

How had Bhogot come to this dangerous moment of his life? When the little herd-boys in India are out on the grasslands from before sunrise until dusk watching the village cattle and goats, they amuse themselves in much the same way that the boys of other lands do. So it happened that kicking a home-made football on a stony field caused the fall which gave Bhogot the ugly compound fracture of his leg. For three months he lay in his wretched little home, crying in pain through long days and nights. His mother was a widow and very poor, and she could not even remain in the house to attend to him. The leg soon became infected, and eventually his whole system was affected. The mother appealed to the village manjhi (chief), but a heathen village headman is not always sympathetic with the misery and suffering of his people. The little boy, although not a Christian, had heard of Benegaria Christian Hospital and begged to be taken there. Finally, some of the neighbors were persuaded to carry him the fifteen miles to our hospital.

During the first weeks, while Bhogot lay quite still on the last cot in the ward, he found amusement in a three-cent mouth-organ which had been given to him and in one of the picture scrapbooks which some American Sunday School children had sent us. Gradually, to our joy, we saw the look of pain vanish and a smile return again! And with all the rice a hungry little Santal boy can eat, and some vegetables and milk, the wasted little body began to fill out and grow strong. In the home the mother could not always provide the daily food necessary, and she had no rice to bring with her to the hospital, so we cared for them both for a while during Bhogot's illness.

Recently Bhogot and his mother have shown a responsiveness towards Christianity, which has met them directly and indirectly during their stay at the hospital. Bhogot tells us that he is going to stay here always and never go back to his home, but naturally his place will soon be needed for other patients. His

mother is giving evidence of a sincere eagerness to know more about God, and arrangements are being made to help them to receive regular Christian instruction in preparation for baptism after their return to their heathen village home.

And so they come. Some are helped and some are healed,—and a few leave with the flicker of a new Light in their souls, where before all had been darkness.

Dear Lord, what joy, what peace to be
About Thy healing work with Thee."

The sequel to the story:—This incident happened some years ago. Today Bhogot is a student at Kaerabani Mission Boys' School and is very happy to be learning to read and write. Both he and and his mother have become Christians.

Ramjon

One day last September before the sultry rainy season had left us, we were just sitting down to our customary afternoon tea. But what was that noise? The whining cry of a child seemed to come from the direction of the veranda. We went to investigate. Yes, there they were, a weary and hungry-looking man with his still hungrier-looking baby in his arms, and a story so familiar out here. The mother was dead and so there was no one to care for the baby and nothing for him to eat. For many, many out here are too poor to buy milk for their babies. It was such a pitiful specimen of humanity! Later we determined by looking at his teeth that he must be over a year old, although the scales registered only ten pounds. (You know that jungle people never know birth dates, so they never celebrate birthdays, either). Too weak and emaciated to sit up, he just drooped over in a little heap with a humped-up back, just as you see him in the picture, and continued his crying.

"Would you not please take him and care for him at the hospital?" asked the father entreatingly.

"Let us first bring him a bowl of milk," we answered, "and then sit down and finish our tea while we talk it over."

Can you imagine, he pushed away the bowl and cried all

the harder! That was because he did not know what milk was. A baby, and milk an unknown thing! However, some bread broken into the milk convinced him that it was edible, and our youngsters stood fascinated in the doorway as they watched the contents of the bowl disappear.

Since that day Ramjon has been a part of our hospital family. A very proper cleaning (particularly of his head), some clothes, big bowls of rice cooked in milk, a clean crib for him to move about in, and gradually Ramjon developed into an adorable little tot. (At first he certainly had not been sweet

Ranjon when he was brought to Benagaria Ranjon as he looked five months later

and nice to look at as babies usually are). During the daytime his crib was out on the veranda in the sunshine, and at night it was brought inside.

Sometimes I found him perched on the long table in the work room while the nurses stood making bandages and dressings; sometimes I found him sitting on the mat beside the woman who sews and patches; but usually he was right in his crib playing with an empty spool or a piece of colored paper. But to see him when he was eating was the most fun! You could not get his attention then, for he was utterly absorbed. I sometimes gasped to see how much he could eat. Actually,

his stomach swelled alarmingly. Finally it became necessary to tell the nurses that they must not give him such large portions. His weight actually increased from ten pounds at his arrival to twenty pounds during the interval of three months.

The Christmas party for the hospital workers and their families was held here in our home, and among the big group squatting closely on mats about the Christmas tree was also little Ramjon, his face shining in the candlelight. When the packages heaped under the tree were to be given out, Ramjon's was the very first name called. A wooden kitty! But even that can bring much joy to a little Indian boy's heart!

Ramjon's father has given his boy to us for adoption, and now we are looking for the right home in which to place him. Several people are interested in adopting him. But we want to be sure he is placed in a good Christian home where he will be loved, and, most important of all, where he will grow up to know and love our Lord Jesus.

Sona

The other day as I paused at Sona's bedside to chat for a moment, she said, "O, memsaheb, I should so like to have a new hymn-book."

"But have you none at your house?" I asked.

"Yes, we have an old tattered one, but my brother and I are always arguing about it for we both want it," she replied.

Sona is an eager, earnest Christian girl whose parents are converts from Mohammedanism and as such constitute one of our few families with that religious background. I know that the days often become tedious for her as she lies on her hospital bed in the long fight against tuberculosis. But she will not be idle; her New Testament lies beside her on her pillow and is frequently in use. Her school books and sewing are also beside her, and with eager, popping eyes she shows us the progress of her work.

Today, as we were about to conduct our usual Sunday afternoon devotions or evangelistic services for the women patients and their many relatives, we became aware of the fact that the majority of them happened to be Bengali-speaking. So I

asked the nurses, who are Santals, "After we have said what we have to say, perhaps Sona will give a witness in Bengali. What do you think?"

Nurse Hanna replied with enthusiasm, "I am sure she will, for she had groups of Hindu and Mohammedan patients and their relatives around her bedside every day as she tells them of our Christian faith."

Then they told me how very "hahara" (wonderful) it was that one day while Sona was lying reading her Bible the people nearby, seeing her, asked her to tell them about it. Since then, every day with courage and enthusiasm this little thirteen year old girl speaks and sometimes sings to the other ward patients about the faith and hope she carries in her heart. And they respond, "Tell us more!"

The last two days she has been telling them in particular about Jesus' words, "I am the Way, the Truth and the Life," challenging them that there is only one way, one faith. Although I could not understand her Bengali words this afternoon, I knew that Sona's message was striking home by the way the patients from the twelve beds were craning their necks to listen as she spoke to them from her own bed. I came away greatly moved, for had I not just seen with my own eyes the fulfillment of the words, "And a little child shall lead them?"

It is a wonderful thought that Christ has His torch-bearers everywhere. This time it was a humble little Indian girl from a desperately poor and illiterate family, lying on her sick-bed.

Then I recalled her yearning for a new hymn-book. A hymn-book! It would not have been amiss if her request had been for entirely different things, this girl who had known so few of the world's material joys. She knew that in saheb (white man) houses there are many good things to eat, there are picture books and bright pieces of cloth. Any one of these might lend brightness to her hours of illness. But Sona, with her quick mind, for she is an honor student, and her radiant heart, has already grasped the essential values of life.

There will be a new hymn-book for Sona, the nicest one I can purchase, for I know that she will treasure it, and use it "to the praise of His glory."

Chapter VII

THE BEAR MAN

We called him the "Bear Man" although he did not receive the nickname until after he had been at the hospital and so after he had become a Christian.

He came to Benagaria Hospital some years ago for an operation, a simple, poor Santal from the hill area on the other side of Dhorompur. His wife had died several years before, and with him came his only other near relative, a grown-up daughter. They were not Christians but had occasionally heard the Gospel preached when the evangelists would come on tour to their district.

His operation made it necessary for them to remain at the hospital for some time, and while there they listened attentively to the Gospel as it was preached in the wards and, when the patient was able to be up and around, in the little hospital chapel. When they were ready to go home, they told us that they had decided to become Christians. This made us very happy, so we sent a letter with them to the missionary at their nearest station, Dhorompur, asking him if he would give them further instruction so they could be baptized.

Before they left Benagaria, we asked them what, especially, it was that had influenced them to want to become Christians. The 'Bear Man' told us that it was the story of the Christ child which they had heard there on Christmas eve. As we always try to do a little bit extra for the patients on the eve before Christmas to make them realize that it is an occasion for rejoicing, I must tell you how it is done and why it was that a greater impression was made on him that evening than the other times he had heard the Gospel.

Late afternoon on the day before Christmas, it has long been our custom at the hospital to gather the workers together and

go from one ward to another just as dusk falls, each one carrying a lighted candle, stopping in every ward to sing and to tell the Christmas story.

Imagine, if you can, a long line of beds, twelve or more, the dark-skinned patients lying there expectantly waiting, and a number of their relatives sitting singly or in groups on mats on the floor. As dusk falls, a group of white-clad Christian Santal men and women come in, each carrying a lighted candle. They stop and sing a Christmas song, and one of their number steps forward and tells simply the story of how God sent His only Son, to be born a poor child, under conditions with which they are so very familiar in a cow-house just like the one they have at home right next to their own dwelling, with only straw in the manger and some coarse pieces of cloth for swaddling clothes. How real to them, who live under conditions so similar to those of the setting of that story. How wonderful to them to hear that this Christ Child came also to them, even to the Santals and the outcastes, to tell them of the God Who loves them and can save them from all sin and all harm, even from the evil spirits, which they fear more than anything else. No wonder that the patients lie quiet and attentive. In the corner bed is the 'Bear Man', but his face does not reveal that the words have reached much deeper than to the organs of hearing. Yet they did reach his very heart, for there, on that Christmas Eve, the Christ Child entered in and took abode, and a soul was turned from emptiness to the fullness, which is Life eternal.

The talk is finished. A song is sung and the singers march out, the flickering candles lighting up their happy faces. As they leave, a lighted candle is placed at the bedside of each patient, a symbol of the Light that came on Christmas Eve.

When the 'Bear Man' and his daughter returned home, they were given instruction and in due time baptized. Their home was quite a distance from the mission station, in among the hills. There they lived very much alone because they were the only Christians in their neighborhood, but every Sunday forenoon they would walk the long distance to church at the

mission station. Nor was this trip without danger because that territory abounded in wild animals, especially leopards and bears. This they knew, and as they would wend their way to church on a Sunday morning, the father would walk ahead, carrying a long, stout pole. This, however, was pretty much a gesture as far as the larger animals were concerned. He might succeed in scaring away a leopard in daytime, but they well knew that a bear would attack in broad daylight and that no stick would be sufficient against one of those beasts. And they walked in constant fear that they might meet a bear.

Then one day it happened. They were on their way to church, walking through a lonely part of the jungle, when lo, a bear stepped out of the under-brush into the path directly in front of them. What should they do? They could not go forward, directly towards the bear. If they turned and ran, he would surely give chase and soon overtake them. A moment they stood there, then the 'Bear Man' remembered: "We are Christians. Our God is stronger than the evil spirits, and He is surely also stronger than a bear." So they dropped to their knees and bowed their heads in prayer that God would save them from the animal. When they looked up, the bear had vanished into the jungle, and they proceeded on to church.

At the church service they told the others of their experience and gave thanks to God for their deliverance, for they entertained not a doubt that God had actually delivered them from the bear. Nor do I. Probably if all of us had the simple, childlike faith of this Santal convert from heathendom, then neither would any of us doubt.

And so the Santal from the Dhorompur hills earned the name of The Bear Man.

Ramon

Ramon came to the hospital not only sick, but poor and unaccompanied by friends or relatives. It was evident that he had been suffering for some time as he ran a low fever, was anemic, and was found to have a large spleen which filled most of his abdomen.

His treatment took a long time, but he improved steadily.

At last, after five or six weeks, he was sufficiently recovered to return to his home, and it was suggested to him that he do so. When a patient has to have hospital diet and has no relative to help him, he becomes a double care to the hospital staff. Besides, his bed was needed for new patients coming in. In spite of this Ramon did not show any intention of leaving the hospital.

After another week had passed, and Ramon was entirely well it became necessary to tell him that now he could stay no longer but would have to go home. His answer was, "Now you have saved me from death, and I want to stay with you always." We explained to him that that was neither desirable nor possible as we had no room or work at the hospital for him. When asked why he wanted to stay he answered, "I want to become a Christian."

At first we thought that this decision was prompted chiefly by the care and the free maintenance that he had received, for it is not unusual in a country where hunger is a chronic affliction of the poorer population, that a person offers to embrace another religion if he can be assured that he will not have to suffer from hunger. So we tried to put him off, telling him that it would be better if he return to his village and stay with his own people.

But Ramon remained firm. He wanted to stay and became a Christian. So at last we became convinced that he was sincere in his decision; that his heart had really been touched by the Gospel message and that he truly wanted to become a follower of Jesus Christ. When that had become clear, there was only one thing to do; namely, to send a letter to Rev. Kampp at Narainpur, who was in charge of the Bengali work at that time, and ask if he could take Ramon, whose language was Bengali and instruct him in preparation for baptism. This he agreed to do, and Ramon went to Narainpur.

After a period of instruction he was baptized and went back to his own village. Here is where the miraculous part of the story begins. Ramon belonged to the muchi or shoemaker caste, or rather outcastes, for they are so considered by the caste Hin-

dus. His home was some thirty miles away where a large colony of muchis eked out a bare living by plying their trade and also engaging in farming on a small scale. The leader of this colony was an intelligent man by the name of Bhogabon. He had long been seeking for the true religion, and as he was able to read and write Bengali, he had searched both the Hindu and the Mohammedan scriptures without finding that which could satisfy him.

Now Ramon came home. He had learned to read, although with difficulty, for Ramon could not be classed among the highly intellectual. Dull and slow of mind, he was just able to spell out the words and sentences in his Bible, which he had brought with him. When the leader, Bhogabon, saw that he had returned, he inquired where he had been. Ramon told of his experiences and of how he had become a Christian. "And this," he said, "is the Christian's book, the Bible."

Thus the story of Ramon introduces another and even more interesting story, that of Bhogabon, the leader of the "muchis". For Bhogabon borrowed the Bible. He read it through once, he read it again, and herein he found what he had been seeking all those years, the true religion, the one true God and salvation through Jesus Christ. Bhogabon became a Christian and a zealous apostle to the rest of his caste, with the result that a strong movement started among the muchis toward Christianity. Although there have been some reverses, it is still continuing today. A Christian congregation has been established, with its own church. There the Christian muchis can attend meetings, no more with the feeling of untouchability and uncertainty but with a consciousness of the freedom that they received when, through Jesus Christ, they became the children of God.

The miracle of this story is, to me, that God could use the unlearned and simple-minded Ramon as an instrument in His service. It has taught me not to look with disdain upon even the least of those whom God has taken as His own.

Chapter VIII

THE LEPER

"He shall cry, 'Unclean, unclean.' All the days wherein the plague is in him he shall be unclean: he shall dwell alone; without the camp shall his dwelling be." Levit. 13:45-46.

When one goes by train through India and stops at some of the smaller stations, it is often that his attention is attracted by the beggars who walk along the platform and utter their peculiar cry as they ask for alms, "Salaam, saheb, ek poesa dao. Salaam, saheb, ek poesa dao." (Please, sir, give me a penny).

If one looks at the outstretched hand, he might notice that it is not whole, only stumps are left where the fingers once had been, and the feet may be without one or more toes and wrapped in dirty rags. Looking closely at the face, the typical "leonine" features of the leper may be made out, the thick lips and nose and the blotched appearance of the skin. Yes, they are lepers. Beggars are numerous in India, and many of them are sufferers from this much-feared malady. Nor are they limited to the railroad stations; they drag themselves on their crippled feet through the dirty streets of village and town and along the hot, dusty country roads, begging at houses and in market place.

It is estimated that there are nearly one million lepers in India. That is probably a conservative figure. But still it would mean one leper to every 400 of the population. In a city the size of Minneapolis, which is about 493,000, there would be 1207 persons afflicted with this disease. There is no official restriction on the movements of these people; they go about freely, working if they can, otherwise begging, visiting the market-places, and mingling with the well population to buy food and other items from the merchants. Lepers have even

been found in the capacity of merchants, selling sweet-meats and other food-stuffs.

In spite of this apparent tolerance, there does exist a general fear of the affliction, which is known as "the big disease." If a member of a family is found to be affected he is usually turned out of the home to shift for himself. However, this treatment may be motivated as much by the knowledge that he will eventually be unable to work and therefore become a burden upon the household as through fear of the disease. One may see a family where one of the parents is leprous and the other clean, and the children may or may not show signs of the disease.

It is true that the contagiousness of leprosy has been greatly over-emphasized in the past. It spreads only through intimate contact with one who has the disease, and probably also by way of the mouth and nose, where the bacteria are frequently found. Much is still unknown about the means of transmission. It is not, however, as contagious as measles or small-pox, but can be more accurately compared to tuberculosis in its degree of contagiousness. The cause is the bacillus lepræ, which was discovered in 1873 by Dr. Hansen of Norway. Undoubtedly undernourishment, poor hygiene, and reduced resistance due to other causes are factors which predispose to the transmission of the malady. It is not hereditary, and infants who are taken from their mothers immediately after birth will not show signs of the disease unless infected later in life.

Until recent years there has been no treatment for leprosy outside of the general medication to relieve discomfort and pain. There was no hope of a cure or of any material improvement. In the countries where the disease has been controlled and nearly eradicated, this has been accomplished by complete segregation of those afflicted. Such a procedure is at present impossible in India with the facilities available and with the large number of lepers found in that country. Fortunately, during the last twenty-five years, treatment with an ester of hydnocarpus oil has given new hope to these unfortunates, hope for permanent improvement and for some, return to normal life with all symptoms gone and the disease arrested, if not

completely cured. During the last two or three years newer preparations have been developed which give promise of even greater results, but of these it is yet too early to make any definite statement.

For many years at Benagaria Hospital the lepers that came to the dispensary were treated along with the other out-patients. Many were referred to Saldoha Leper Colony for admittance and treatment, but a large number continued to live in their homes in the villages. About the year 1939 the government leper authorities, convinced that the most practical way of reaching these scattered cases was by establishing treatment centers throughout the district, requested us at Benagaria Hospital, among others, to begin a leper clinic in connection with the hospital. This we were glad to do; in fact it had been con-

Lyser Clinic

templated for sometime but had been put off because our staff was over-taxed with work as it was. But now it was to be. A clinic building was erected in 1941-42, and the patients began to arrive.

It proved to be a very satisfying work. Clinics were held twice weekly and at times the attendance was as high as fifty each day. The patients were thankful for the help they received, and it was gratifying to see the swollen limbs and blotched faces gradually take on a more normal appearance.

The problem of ridding India of leprosy is still an unsolved one. The task is enormous, and no solution seems practical at the present time. On the other hand, much has been done for

the relief of these unfortunates by providing homes, food, clothing, and treatment for them in leper hospitals and colonies. The Christian missions have been pioneers in this task; in fact about ninety per cent of the work done for lepers has been performed by the various Christian missions. Moreover, the majority of the staff members in government-owned leper hospitals are Christians. The reason is simple, for only those whose hearts have been touched by God are willing to cleanse the sores and dress the affected limbs of those who suffer from so loathsome a disease. In our mission two such leper colonies, Saldoha in Santal Parganas and Santipara in Assam, are caring for hundreds of patients. They not only give them physical care, but also point them to Him, Who has power to give renewal both to body and to spirit. The work that has been done and is being done in these institutions provides a happy chapter in the history of our mission.

Chapter IX

THE WAR YEARS

Although India entered the war along with England in 1939, it was some time before we felt the real effects of the conflict in the way of shortages of necessary material and drugs for the hospital. The first items that became difficult to obtain were imported foods and medicines, and eventually these became practically unavailable. After Burma was taken by the Japanese, things became considerably worse. Kerosene and quinine were among the items formerly received from Burma and the Dutch East Indies, and they now became hard to get and were eventually rationed.

The entire supply of quinine found in India was taken over by the government, and they were very slow in distributing it to the hospitals. Our stock gave out, and I sought the aid of the local government authorities without avail. A trip to Patna, the capital of our province, netted only one pound, hardly enough for one day in the busy malarial season. We decreased the amount given each patient to a dose which might stop the fever temporarily, but which would not prevent it from recurring after a few days. At last there was no more, and we had to tell the patients that we could not help them. It was heart-breaking to see them come in, shaking with chills and burning with fever, and to be unable to relieve their suffering.

Some quinine was purchased in the black market at exhorbitant prices, but that also was entirely insufficient. It was not until December, 1943, that we again received a supply which tided us over for another few months. Atabrine was unavailable except in small quantities at various times.

The kerosene shortage also caused great inconvenience and taxed our ingenuity in finding a suitable substitute. At the hospital, kerosene lanterns were used to light the wards and rooms at night. Now our allowance was cut to one-third of the

former consumption, so we had to find another means of lighting the wards. Here the good Santals came to the rescue, for did they not have light in their houses before the lantern ever came to India? Many of the poorer homes still used the ancient method, that of taking oil pressed from the seed of a flowering tree found out there, placing it in an earthen or stone saucer, and into this inserting a wick made from an old rag. So here was the solution to the lighting problem. Such an oil lamp, probably similar to those used in the Biblical story of the Ten Virgins, was placed in each room when darkness came. It gave a dim, flickering light, but the patients were satisfied. It was a bit smoky, too, and if the night nurse forgot to replenish the oil sometime during the night, the ward would be plunged into darkness for a while, as one saucerful of oil did not last the whole night through.

A more difficult situation developed in the sterilizing room. There we had used a three-burner kerosene stove to boil the instruments for operations, and kerosene was also used for the pressure sterilizer. The latter could not be operated in any other way, so it became necessary to find a substitute for heating the water for the instruments. The method which eventually was decided upon was to make two small stoves out of cylindrical oil tins. This was done by plastering the inside of the tins with a layer of clay, putting in a grate, and making an opening for draft. Charcoal was used as fuel. It was somewhat smoky and therefore could not be kept in the sterilizing room, so the instruments were boiled outside in one of the cook-houses and carried in when ready. It was a bit inconvenient and meant that one of the nurses had to get up very early in the morning to start the fires. But the work was carried on, and instead of the number of operations decreasing during these years, the statistics even showed a slight increase.

At this time recruiting was going on for the Indian army. With its offer of much higher pay than we were able to give, it was unavoidable that some of the compounders were induced to leave and go into army or government service. At one time about half of our experienced compounders left us. We

did take in probationers, but without a period of instruction they could not adequately fill the places of those who had gone. But we carried on, the remainder doing double duty and Miss Krohn and Mrs. Ostergaard filling in where the need was greatest.

The year of 1943 will be remembered as the famine year in Bengal and the neighboring provinces. In the spring of that year there was a noticeable rise in the prices of food-stuffs, but people were assured that there was plenty on hand and that there was no reason to be afraid.

At the hospital the demand for free food became so great that by the middle of August the supply of rice and oil which should have lasted us until the end of the year was exhausted. For a while we tried to give the patients maize (corn) instead, but many were unfamiliar with its preparation and did not like the change. At last we were able to purchase rice in the black market but at a price nine times the pre-war normal.

It was about the middle of August that we began to see the effects of the famine. Stragglers or whole families would arrive, mostly from the Bengal side where they had gone to seek work, their limbs swollen and their abdomens distended. They were too listless to drag themselves any farther. Some died by the roadside even in our area. It was much worse in Calcutta and other districts of Bengal, where they died like flies, so that the dead bodies in the streets became a health problem of first magnitude.

At Benagaria we admitted the worst cases and tried to build them up again. This was very difficult. We had to begin gradually, starting with rice water and increasing to a milk mixture, little by little adding easily digested foods until, after many days and sometimes months, the patients could tolerate a full diet.

In spite of these precautions many died; they were too weak and depleted to be able to respond. If we had had some strength-giving soups, sufficient milk, digestible proteins and vitamins to give them, many more could have been saved, but our supply of milk and eggs was very limited, and the other items did not even exist.

Many who asked for admittance, but who were able to carry on, were given food and sent away, as there was not room for all. Others, weak from starvation, also suffered from some concurrent disease, usually tuberculosis and dysentery. They were taken in and helped as much as possible.

Pitiful it was to see the shrunken cheeks, the distended abdomens and the dull, listless eyes, especially of starving children. We felt that we hardly had the right to sit down to a full meal in the midst of all that suffering. A family group comes to my memory. The father had recently died from tuberculosis.

DYSENTERY PATIENTS

The widow and three starving children came to the hospital. In spite of their hunger and undernourishment these little tots never whimpered nor cried; they were just silent. When the mother was asked how it could be that they did not complain when they were hungry, she answered, "Saheb, they are used to it."

The famine continued that fall and the early part of the winter but eased up during the winter and spring months. This was in Bengal. For the local people in our area the conditions, although bad, did not on the whole reach famine proportions. A good crop, harvested in November and December, brought welcome relief.

Chapter X

THE STATUS OF THE HOSPITAL

Benagaria Christian Hospital is a long, low building of brick and mortar, with white-washed walls and a veranda running the full length of the structure. It is built in a rectangle, the one end of which is open to face a large, open area where in the shade of banyan trees there is space for ox-carts, and for both patients and oxen to stop and rest. One side and the closed end of the rectangle contain wards. In the center is found a well-laid-out garden which at most times of the year presents a varied display of flowers and shrubs. The patients' cook-houses can be seen as long, low buildings to the extreme left and at the center of the closed end of the rectangle. The unit to the right contains consultation rooms, dispensary, dressing room, laboratory, store room and operating room.

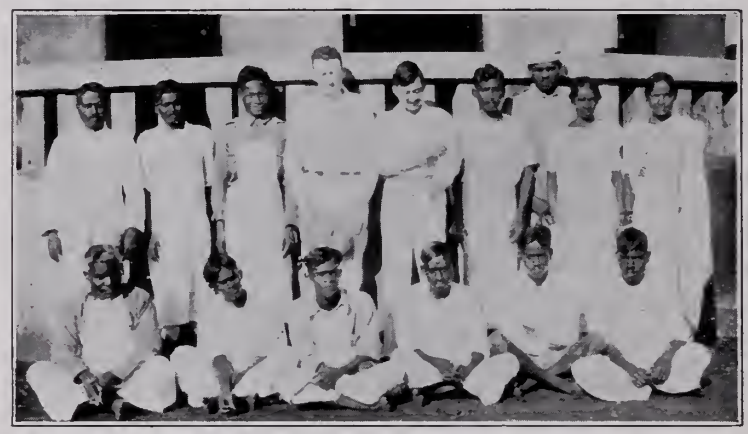
The operating room is equipped to permit most major operations. It boasts the only electric light in the hospital, produced by a small motor-generator of sufficient power to light the operating and sterilizing rooms. The operating room has through the years been a busy place, running from 250 to 350 major operations per year including eye cases. These vary from cataracts to Cæsarian sections. Providing a suitable form of anesthesia has proven a difficult problem and one that is not yet solved.

THIS PATIENT REFUSED OPERATION

The laboratory keeps two men busy making numerous

examinations daily. This is a very important branch of the institution, more important than in a hospital at home, as the final diagnosis of many tropical diseases depends upon the microscopic findings.

Of the medical diseases seen here, malaria is by far the most numerous, running 10,000 to 11,000 cases a year. Others are leprosy, kala-azar, sprue, intestinal parasites, skin diseases, venereal diseases, tumors, cancer, in fact, all the diseases known



DR. OSTERGAARD AND HIS ASSISTANTS (The Hospital Staff)

in Western countries in addition to those peculiar to the tropics.

The staff has usually consisted of approximately the following: two doctors, one missionary nurse, four to six female practical nurses, twelve to fourteen male nurses, two evangelists, and other general workers. All these are Christian except the Bengali doctor. With one or two exceptions all the native workers are Santals. All this data is as of 1944, the last year we were in India.

The nurses and compounders with a few exceptions have received their training locally. Some have gone away for special courses, and the laboratory technicians have received their training elsewhere. Instruction in the form of lectures has been given both men and women, and the practical work super-

vised. A three-year course of study was introduced some years ago for the male nurses, following that suggested by the government, which has fitted them very well for the various tasks of the nursing profession. Entrance qualifications for training were set at eighth grade but a number of applicants have had several years of high school. The women nurses, under the tutelage of the missionary nurse, were trained in practical nursing and received a thorough course in midwifery.

DR. CHATTERJEE

The work, then, has been carried on chiefly by native workers, with two or at the most three missionaries on the staff. More efficient work might have been accomplished with more expert help and better equipment, but as it is, tens of thousands have been helped through the years.

Attendance at the hospital has grown steadily from year to year, reaching the highest figures in 1944 when 34,163 cases were seen in the out-patient department and 1,483 admitted to the hospital.

In 1944 a Managing Committee (Board of Directors) was formed for the purpose of taking some of the responsibility from the shoulders of the hospital superintendent as well as of giving our Indian Christian brethren a part in the management of hospital affairs. It is hoped that this may prove a blessing both in the running of the hospital and, not least, in stimulating a sense of responsibility in members of the indigenous church toward an institution with which they are so intimately concerned.

Chapter XI

THE FUTURE

The task of missions, as someone has crudely put it, is "to work itself out of a job." To put it more clearly, it is to preach the Gospel and to prepare the people in such a way that they eventually will be able to take over the work and make the missionaries superfluous. How near or distant that time may be no one can tell. It is safe to predict, however, that the medical side of missions will have to receive help for a long time to come. The high type of professional training required of nurses and doctors precludes that a sufficient supply of such Christian leaders will be available in the near future. Our efforts should be directed toward enlisting and training these men and women, offering help and encouragement through financial aid for their education, and providing adequately paid positions upon graduation.

Another important factor is the cost of running a hospital, which, especially in poorer communities such as the one in which Benagaria Hospital is located, can not easily be made self-supporting.

This necessarily brings up the question of the relation between the Indian Christian Church and the hospital.

The care of the sick has always been a responsibility of the Christian Church, from the time Christ Himself healed those that were ill and bade His disciples to do the same. In medieval times we know that the monasteries were a refuge for the wounded and ill, and the monks fed the unfortunates and nursed them back to health. The first care for lepers in the Scandinavian countries was given by Catholic brothers, who established "homes" where these unfortunates could be kept and ministered to.

In our country, from the early days, the various church bodies

have seen it as their responsibility to establish hospitals and to care for the sick. Even today,, when the government is contributing greatly in the Good-Samaritan task, the cities, both large and small, are dotted with hospitals erected and maintained by the churches and bearing such names as Methodist, Presbyterian or Lutheran Hospitals. In Minneapolis alone there are four Lutheran Hospitals.

AN OUT-DOOR CLINIC

There can be no doubt that the church should continue in this labor of mercy and thus retain the very important opportunity for Christian service and influence that it brings. It is true that the individual Christian doctor and nurse may also in government institutions exert his or her influence and that much valuable service has been rendered that way, but there is no doubt that it is more difficult to give true expression to the ministry of healing in a secular institution than in one in which all are united in one purpose and in one spirit.

On the mission field the churches, through their envoys, the missionaries, have established hospitals, leper colonies, and tuber-

culous sanatoria, and so out there have retained as their own the sphere of the ministry of healing. Those who have given considerable thought to the matter are in agreement that the new church should gradually be given a responsible share in the work in order to keep the ministry of healing a part of the church. The following extract is taken from a report from the Tambaram Meeting. "The ministry of healing and health should, from the outset, be integrated in the life of the indigenous churches. It is essential to foster in them a sense of responsibility for an enterprise that they have considered to be a concern of the missions, and to give them a larger share in the work."

How this can be done is the question that faces us as the time comes nearer for the transfer of responsibility from mission to indigenous church.

The economic factor is important. When the new church eventually is to take over the hospitals, these must be practically self-supporting, for the church will not be able to contribute much in actual cash for their upkeep. In the past Benagaria Hospital has not been self-supporting. It has received twenty-five to thirty per cent of its budget in fees, when missionary salaries are not included. This percentage could be increased, but to do that several changes, both in management and in policy, would have to be made.

It has been the aim of Benagaria in the past to take care of the poorer classes of people, those who could pay very little for their medicine and care. This meant that nothing special was done to win the patronage of the more well-to-do patients. They had to stand in line and await their turn with the lower classes and outcastes, with only very little exception. As this is entirely contrary to the Indian mentality, it followed that comparatively few of the well-to-do group came to the hospital.

This could be changed. Not that the attention given to the poor people should be decreased, far be it from that, but that facilities should be provided which would attract the higher classes. That would mean an additional doctor who could give as much time as needed to that type of patient; it would re-

quire private examining and treatment rooms and more personal attention. With these improvements the better class of patients would undoubtedly come, and the hospital would receive a greater income.

For the Christian population especially, some type of prepaid hospital and medical service similar to the Blue Cross plan here at home might be introduced. This has proved to be a great boon to many hospitals here, eliminating many of the financial worries of former days.

The problem at present, however, is not only economical; it is also in the Christian people's attitude to Benagaria Hospital.

They view it much as they do other mission property or institutions, as something they have a right to benefit from but for which they assume very little moral or financial responsibility. If they could be made to feel that it is their hospital, an expression of their Christianity and so also their responsibility, much would be gained.

This attitude will have to be developed gradually. The functioning of the Managing Committee will undoubtedly help by giving the Indian Christians a voice in the management. Various church groups, such as Ladies' Aids, could be given a part in making bandages, gauze sponges, and clothing for the hospital. Young people should be encouraged to enter nurses' training or to take up medicine and so have an actual part in this work of mercy.

These changes cannot come about in a day or a year. It will take time. Meanwhile the ministry of healing at Benagaria Christian Hospital goes on under the capable leadership of new and able missionaries. May God bless that work that it may always be a witness to His all-encompassing love and to the Glory of His name.

THE HEALING OF CHRIST

By John Greenleaf Whittier

So stood of old the holy Christ
    Amidst the suffering throng;
With whom His lightest touch sufficed
    To make the weakest strong.

That healing gift He lends to those
    Who use it in His name;
The power that filled His garment's hem
    Is evermore the same.

For lo! in human hearts unseen
    The Healer dwelleth still,
And they who make His temples clean
    They best subserve His will.

The holiest task by heaven decreed,
    An errand all divine,
The burden of our common need
    To render less, is thine.

The paths of pain are thine. Go forth
    With patience, trust and hope;
The suffering of a sin-sick earth
    Shall give thee ample scope.

Beside the unveiled mysteries
    Of life and death go stand,
With guarded lips and reverent eyes
    And pure of heart and hand.

So shalt thou be with power endued
    By Him Who went about
The Syrian hillsides doing good
    And casting demons out.

The good Physician liveth yet
    Thy friend and guide to be:
The Healer of Genesareth
    Shall walk the rounds with Thee.

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